| STATEMENT OF DEFICIENCIES X | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | SURVEY | | |
|-----------------------------|--|------------------------------|--|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | , DDIG | 00 | COMPL | ETED |
| | | | A. BUII B. WIN | | | 05/09/2 | 011 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| MONDO | E HOUSE | | 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | |
| | | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| R0000 | | | | | | | |
| | | | | | | | |
| | This visit was fo | r a Post Survey Revisit | R(| 0000 | Submission of this response | | |
| | (PSR) to the Stat | te Residential Licensure | | | Plan of Correction is NOT a admission that a deficiency of | - | |
| | Survey complete | ed on 02/21/11. | | | or, that this Statement of | SXISIS | |
| | | | | | Deficiencies was correctly ci | ted. | |
| | Survey Date: 05/09/11 | | | | and is also NOT to be consti | | |
| | | | | | as an admission against inte | | |
| | Facility Nymhan 004016 | | | | by the residence, or any | | |
| | Facility Number: 004016 Provider Number: 004016 Aim Number: NA | | | | employees, agents, or other | | |
| | | | | | individuals who drafted or m | • | |
| | | | | | discussed in the response of | r Plan | |
| | | | | | of Correction. In addition, preparation and submission | of | |
| | Survey Team: | | | | this Plan of Correction does | | |
| | Sharon Whitema | ın RN TC | | | constitute an admission or | 1101 | |
| | Marla Potts RN | | | | agreement of any kind by the | е | |
| | Melinda Lewis F | 2N | | | facility of the truth of any fac | | |
| | Wichinga Lewis 1 | | | | alleged or the correctness of | any | |
| | C 1 D. 17 | 7 | | | conclusions set forth in this | | |
| | Census by Bed T | | | | allegation by the survey age | ncy. | |
| | | 34 | | | | | |
| | Total: | 34 | | | | | |
| | | | | | | | |
| | Census by Payor | Source: | | | | | |
| | Other: 34 | | | | | | |
| | Total: 34 | | | | | | |
| | | | | | | | |
| | Sample: 04 | | | | | | |
| | Sample. 04 | | | | | | |
| | TTI C. P. | 1 1.0. 1. | | | | | |
| | | dential findings are cited | | | | | |
| | in accordance wi | ith 410 IAC 16.2-5. | | | | | |
| | | | | | | | |
| | Quality review c | completed 5-10-11 | | | | | |
| | Cathy Emswiller | - | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ZTC12

Facility ID:

004016

TITLE

If continuation sheet

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | | | COMPLETED 05/09/2011 | | |
|---|---|--|--|--|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (f) The resident must be discharged if the | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | ΓE | (X5) COMPLETION DATE |
| R0006 | resident: (1) is a danger to a (2) requires twenty comprehensive nu comprehensive nu (3) requires less the per day comprehe comprehensive nu rehabilitative thera into a contract with provider of the resident (5) meets at least three (3) criteria un medically stable a meet the resident (A) Requires total (B) Requires total (C) Requires total transferring. Based on observations and the facility after the facility after behaviors: continuing the rugs and fut the kitchen, wand break room taking medications, for | the resident or others; y-four (24) hour per day ursing care or ursing oversight; nan twenty-four (24) hour ensive nursing care, ursing oversight, or apies and has not entered in an appropriately licensed endert's choice to provide by stable; or two (2) of the following enless the resident is not the health facility can 's needs: assistance with eating, assistance with toileting, assistance with eating, assistance with eating, assistance with eating assistance with eating assistance with eating, assistance with eating, assistance with eating, assistance with eating as | RO | 0006 | R 006 410 IAC 16.2-5-0.5 (f) (1-5) Scope of Residential Complished for those residents found to have be affected by this deficient practice? Resident #9 was re-educated to our smoking by the Wellness Director. Resident #9 was re-assesse the Wellness Director utilizing smoking assessment and wadeemed unsafe to smoke with staff supervision. Residence a plan in place to remove smoking paraphernalia and provide to resident upon requonly under staff supervision. Despite interventions resident | oolicy d by g our ss thout had | 06/17/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1ZTC12 Facility ID:

004016

If continuation sheet

Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 05/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2770 S ADAMS RD MONROE HOUSE **BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE was found to be non compliant and was determined to be Findings include: inappropriate for continued placement at Monroe House. On 5/9/11 at 11:00 A.M., Resident # 9's Resident #9 was issued a notice room was observed with Housekeeper # 1. of involuntary discharge on 5/20/2011. Monroe House has The room was observed to have burn notified all appropriate parties and holes in the area rugs in the living area, is currently assisting resident #9 the recliner, and on top of the television. with appropriate placement. These were ashes observed on the toilet How the facility will identify other residents having the seat in the bathroom. A pipe and rolling potential to be affected by the papers were observed on the bed side same deficient practice and table. In an interview with Housekeeper # what corrective action will be 1 at this time she indicated the room had taken? No other residents were been cleaned last Thursday, and she found to be affected. Residents who smoke have been indicated Resident # 9 did smoke in his re-assessed by the Wellness room. Director utilizing the smoking assessment and have been found to be appropriate for continued The clinical record for Resident # 9 residency at Monroe House. indicated was reviewed on 5/9/11 at 10:00 What measures will be put into A.M. The record indicated Resident # 9 place or what systemic had diagnoses that included but were not changes will the facility make limited to Alzheimer's disease. to ensure that the deficient practice does not recur? The staff at Monroe House was A Mini Mental Assessment.. dated re-educated to our policy and 1/18/11, indicated a score of 21. The form procedure regarding smoking indicated "...25 or less suggestive of safety requirements. Residents impairment..." identified as smokers will be assessed by the Wellness Director or Designee upon The Service Plan, dated 3/7/11, indicated admission and as needed to "...Orientation/Behavior/Safety- Do you ensure continued compliance. have trouble recalling the day, date, time, How will the corrective action(s) will be monitored to or where you are located? (This was ensure the deficient practice marked with an X.). Do you need will not recur, i.e., what quality assistance with management of any of the

Facility ID:

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE 00 COMPLETED | | | | |
|--|---|------------------------------|--|--------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | | |
| | | | B. WIN | | | 05/09/20 |)TT |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| MONDO | - 1101105 | | 2770 S ADAMS RD | | | | |
| MONRO | E HOUSE | | | BLOOM | IINGTON, IN47403 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TΕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | 4 | DATE |
| | following behaviors? These behaviors could result in a denial or discharge. (This | | | | assurance program will be into place? For the next thre | | |
| | | | | | months the Wellness Director | | |
| | | an X). Needs occasional | | | designee will perform a rand | | |
| | | ety or agitation requiring | | | weekly review of residents w | | |
| | _ | t? (This was marked with | | | smoke for a period of 4 week | | |
| | | noke? ALC [Assisted | | | and then quarterly thereafter Finding will be reviewed at the | | |
| | Living Concepts | • | | | end of the quarter to determi | | |
| | ` | s was marked with an X). | | | the need for continued | | |
| | Notes: Smokes in | ndependently" | | | monitoring. Findings sugges | | |
| | | | | | of compliance will result in no further routine monitoring. | ° | |
| | In an interview with the Wellness | | | | iditile rodtile monitoring. | | |
| | Director, on 5/9/11 at 11:30 A.M., she | | | | | | |
| | | n the service plan | | | | | |
| | | s a concern for the | | | | | |
| | resident. | | | | | | |
| | | | | | | | |
| | | vices Notes, dated 3/7/11 | | | | | |
| | • | icated "Writer went to | | | | | |
| | residents room to | take him dessert. Writer | | | | | |
| | knocked on resid | ents door and got no | | | | | |
| | response, writer of | - | | | | | |
| | | nt sitting on his bed | | | | | |
| | | tte. Writer asked resident | | | | | |
| | to extinguish the | cigarette and explained | | | | | |
| | that smoking is p | rohibited in the house. | | | | | |
| | Resident cupped | cigarette and walked past | | | | | |
| | writer and down | hallway to the | | | | | |
| | courtyard." | | | | | | |
| | | | | | | | |
| | The Resident Ser | vices Notes, dated 3/7/11 | | | | | |
| | (no time), indicat | ted "Resident was see | | | | | |
| | (sic) going into k | itchen he went in and | | | | | |
| | took some chips | | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | E CONSTRUCTION 00 | <u>`</u> | DATE SURVEY COMPLETED | | | |
|---|---|------------------------------|--|---------------|---|----------|--|--|
| | | | A. BUILDING B. WING | - | 05 | /09/2011 | | |
| | PROVIDER OR SUPPLIEF | ! | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | ID PREFIX | (EACH CORREC | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | GROSS REFEREN | DEFICIENCY) | DATE | | |
| | | rvices Notes, dated 3/9/11 | | | | | | |
| | 1 | licated "Writer took | | | | | | |
| | | k and residents room was | | | | | | |
| | I - | led like cigarette smoke. | | | | | | |
| | | resident that he should | | | | | | |
| | , , | outside and not in his | | | | | | |
| | | old writer that he | | | | | | |
| | | would not smoke in his | | | | | | |
| | apartment." | | | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | | |
| | 3/20/11 at 3:00 A.M., indicated "As I was | | | | | | | |
| | | l (Not Resident # 9's | | | | | | |
| | 1 | cigarette smoke smell. I | | | | | | |
| | · * * | dent # 9) had just finished | | | | | | |
| | ` | l if he replied "No, I'm in | | | | | | |
| | 1 | I him that he cannot | | | | | | |
| | smoke in his roo | | | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | | |
| | | e), indicated "Resident | | | | | | |
| | ` | king in his room again. | | | | | | |
| | 1 | ed many times not to do | | | | | | |
| | | really bad and other | | | | | | |
| | resident are com | | | | | | | |
| | resident are com | pianing. | | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | | |
| | | P.M., indicated "Staff | | | | | | |
| | | facility through kitchen | | | | | | |
| | | resident in kitchen. He | | | | | | |
| | was going through | gh cabinets and holding a | | | | | | |
| | | his hand. Writer asked | | | | | | |
| | 1 ~ | kitchen area and | | | | | | |
| | explained that fo | or resident safety the | | | | | | |

PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

| | (X3) DATE SURVEY |
|---|------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | COMPLETED |
| B. WING | 05/09/2011 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | • |
| 2770 S ADAMS RD | |
| MONROE HOUSE BLOOMINGTON, IN47403 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) | DATE |
| kitchen was an employee only area as | |
| marked on kitchen entrance door. As | |
| writer and resident were exiting kitchen, | |
| nurse was coming in and also spoke with | |
| resident about being in the kitchen." | |
| | |
| The Resident Services Notes, dated | |
| 3/28/11 (no time), indicated "Resident's | |
| daughter (name) was inwill PU [pick | |
| up] resident Fri 4/1 to visit MD and | |
| review lab results, medication list and | |
| resident's current condition. Reviewed | |
| with daughter the need for MD to be | |
| made aware of the recent increase in | |
| behaviors so MD may do an evaluation to | |
| determine appropriate interventions." | |
| | |
| The Resident Services Notes, dated | |
| 4/12/11 at 1500 (3:00 P.M.), indicated | |
| "Resident has been observed 3 x [times] | |
| today searching around front desk area- | |
| states he needs some cigarettes, then used | |
| phone to call family to tell them he needs | |
| cigarettes. Reminded resident that he had | |
| already called someone. Resident says | |
| someone is bringing him some." | |
| | |
| The Resident Services Notes, dated | |
| 4/20/11 at 11:00 A.M., indicated "Spoke | |
| with daughter (name) RE: res [resident] | |
| smoking in room. Daughter in agreeance | |
| (sic) with nursing staff keeping res | |
| smoking supplies. Spoke with res res in | |
| agreeance (sic) with keeping smoking | |

004016

| | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
|----------|---|--|--------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | | B. WIN | | | 05/09/2 | U11 |
| NAME OF | PROVIDER OR SUPPLIEI | R | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| MONDO | E HOUSE | | | 1 | ADAMS RD | | |
| MONRO | E HOUSE | | | BLOOM | IINGTON, IN47403 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | † | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | materials with staff et [and] voiced | | | | | | |
| | 1 | f being able to ask staff | | | | | |
| | | time he wanted one. res | | | | | |
| | 1 | nd (name) RN to search | | | | | |
| | 1 | oking supplies. Writer | | | | | |
| | | e et 2 lighters res denied | | | | | |
| | having any other | r materials." | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | |
| | 4/28/11 (no time), indicated "Called sister | | | | | | |
| | to come get him to get ciggestes (sic) said | | | | | | |
| | sister was coming got off phone walked | | | | | | |
| | | as ask to come back in | | | | | |
| | 1 | told me to shut up had to | | | | | |
| | 1 | to get in (sic) back in. | | | | | |
| | 1 | told us that she wasn't | | | | | |
| | 1 | | | | | | |
| | 1 | m. But his (sic) telling | | | | | |
| | everyone she is. | | | | | | |
| | The Resident Se | rvices Notes, dated 5/2/11 | | | | | |
| | 1 | ited "Spoke with res about | | | | | |
| | . /: | g [building]. Explained he | | | | | |
| | 1 | elf and staff would go out | | | | | |
| | | for cigarettes. Res | | | | | |
| | voiced understar | • | | | | | |
| | | ·· · · · · · · · · · · · · · · · · · · | | | | | |
| | The Resident Se | ervices Notes, dated 5/6/11 | | | | | |
| | 2210 (10:10 P.M | 1.), indicated "Resident | | | | | |
| | found to have go | one into employee pocket | | | | | |
| | | noney, candy bar and OTC | | | | | |
| | 1 | r] med [medication]. | | | | | |
| | Candy bar and OTC med found in | | | | | | |
| | 1 - | He had also taken his | | | | | |
| | 1 | ack of cigarettes found in | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | (X3) DATE COMPL | | | |
|---|---|---|--|------------------|---|---------------------|------|--|
| | | | A. BUILDING B. WING | | | 05/09/2011 | | |
| | PROVIDER OR SUPPLIEI | !! R | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | | DE CUIDERE EL LU CE CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | PREI | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION COMPLETI | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TA | G | DEFICIENCY) | VIE. | DATE | |
| | his room" | | | I | | | | |
| | at 9:00 A.M., indin room after this a.m. meds. This administer a.m. put them under I swallow med. R swallowing, nor he wanted his monitor" In an interview of Director, on 5/9/indicated the metaken was Mucin medication). She employee break locked. | rvices Notes, dated 5/7/11 dicated "CNA found pills is nurse had administered nurse attempted to meds again and saw resinist tongue. Asked res to eports no difficulty refusal to take med. Said eds. Will continue to with the Wellness /// 11 at 11:15 A.M., she edication Resident # 9 had nex (decongestant e stated the door to the room was supposed to be | | | | | | |
| | | with the Wellness | | | | | | |
| | · · | /11 at 11:50 A.M., she | | | | | | |
| | 1 | s not aware of any | | | | | | |
| | smoking assessn | nents done by the facility. | | | | | | |
| | On 5/9/11 at 11: | 45 A.M., the Residence | | | | | | |
| | | ed the facility policy and | | | | | | |
| | | noke Free Policy, dated | | | | | | |
| | _ | indicated "If any | | | | | | |
| | | that is grandfathered and | | | | | | |
| | | nue smoking in his/her | | | | | | |
| | | se of prior contractual | | | | | | |
| | _ | dangers the health or | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | |
|--|---|--|---|--|---------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLETED 05/09/2011 | | |
| | | | B. WING | | 05/09/2011 |
| NAME OF F | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | |
| MONRO | E HOUSE | | | ADAMS RD IINGTON, IN47403 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | | elves or others, they will | | | |
| | be immediately prohibited from smoking. | | | | |
| | _ | partment and outside of | | | |
| | | r smoking will also be | | | |
| | _ | this resident violated | | | |
| | | or does not properly | | | |
| | - | " In an interview with | | | |
| | | rector, on 5/9/11 at 12:15 d Resident # 9 was not | | | |
| | * | to be smoking in his | | | |
| | apartment. | to oc smoking in ins | | | |
| | apartment. | | | | |
| | | | | | |
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PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPLETED 05/09/2011 | | |
|---|---|---|--|---|---|--|--|
| | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 ID PROVIDER'S PLAN OF CORRECTION (X: PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE | | | | |
| | PREFIX TAG | | COMPLETION DATE O6/17/2011 | | | | |
| | resident was not supervision to proin his room and be furniture and rug adequate supervision to prove at night; and faile supervision to prowandering into the and taking money counter medicine "pocket book." | eglected, in that the provided adequate event him from smoking ourning holes on his s; failed to provide sion to prevent the indering into the kitchen ed to provide adequate event the resident from the employee break room by, candy, and over the efform an employee This finding affected 1 of its wed for provision of Resident #9) | | What corrective action(s) will accomplished for those reside found to have been affected by deficient practice? Resident #9 was re-educated to smoking policy by the Wellness Director. Resident #9 was re-assessed by the Wellness Director was deemed unsafe to smoke was deemed unsafe to smoke was taff supervision. Residence has plan in place to remove smoking paraphernalia and provide to reupon request only under staff supervision. Despite interventing resident was found to be non compliant and was determined inappropriate for continued placement at Monroe House. | nts y this o our s rector ent and without ad a ng esident ons | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ZTC12 Facility ID:

004016

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 05/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2770 S ADAMS RD MONROE HOUSE **BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident #9 was issued a notice of Findings include: involuntary discharge on 5/20/2011. Monroe House has notified all On 5/9/11 at 11:00 A.M., Resident # 9's appropriate parties and is currently room was observed with Housekeeper # 1. assisting resident #9 with appropriate The room was observed to have burn placement. holes in the area rugs in the living area, How the facility will identify other the recliner, and on top of the television. residents having the potential to be These were ashes observed on the toilet affected by the same deficient seat in the bathroom. A pipe and rolling practice and what corrective papers were observed on the bed side action will be taken? No other residents were found to be table. In an interview with Housekeeper # affected. Residents who smoke have 1 at this time she indicated the room had been re-assessed by the Wellness been cleaned last Thursday, and she Director utilizing the smoking indicated Resident # 9 did smoke in his assessment and have been found to room. be appropriate for continued residency at Monroe House. The clinical record for Resident # 9 What measures will be put into indicated was reviewed on 5/9/11 at 10:00 place or what systemic changes A.M. The record indicated Resident # 9 will the facility make to ensure had diagnoses that included but were not that the deficient practice does not recur? limited to Alzheimer's disease. The staff at Monroe House was re-educated to our policy and A Mini Mental Assessment., dated procedure regarding smoking safety 1/18/11, indicated a score of 21. The form requirements. Residents identified as smokers will be assessed by the indicated "...25 or less suggestive of Wellness Director or Designee upon impairment..." admission and as needed to ensure continued compliance. The Service Plan, dated 3/7/11, indicated "...Orientation/Behavior/Safety- Do you How will the corrective action(s) will be monitored to ensure the have trouble recalling the day, date, time, deficient practice will not recur, or where you are located? (This was i.e., what quality assurance marked with an X.). Do you need program will be put into place? assistance with management of any of the For the next three months the following behaviors? These behaviors Wellness Director or designee will

| l l | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | | | | |
|-----------|--|--|-----------------------|-----------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | | |
| | | | B. WIN | G | | 05/09/2 | U11 |
| NAME OF F | PROVIDER OR SUPPLIER | | - | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | l | ADAMS RD | | |
| MONRO | E HOUSE | | | BLOOM | IINGTON, IN47403 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | re l | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG DEFICIENCY) | | | DATE |
| | could result in a denial or discharge. (This | | | | perform a random weekly revie residents who smoke for a perio | | |
| | | an X). Needs occasional | | | 4 weeks and then quarterly | NG 01 | |
| | | ety or agitation requiring | | | thereafter. Finding will be revie | wed | |
| | ~ | t? (This was marked with | | | at the end of the quarter to deter | | |
| | ' | noke? ALC [Assisted | | | the need for continued monitori | - | |
| | Living Concepts | residences are | | | Findings suggestive of compliant | nce | |
| | smoke-free. (This was marked with an X). | | | | will result in no further routine | | |
| | Notes: Smokes in | ndependently" | | | monitoring. | | |
| | | | | | | | |
| | In an interview with the Wellness | | | | | | |
| | Director, on 5/9/11 at 11:30 A.M., she | | | | | | |
| | indicated the X on the service plan | | | | | | |
| | indicated this wa | s a concern for the | | | | | |
| | resident. | | | | | | |
| | | | | | | | |
| | The Resident Ser | rvices Notes, dated 3/7/11 | | | | | |
| | | icated "Writer went to | | | | | |
| | · · | take him dessert. Writer | | | | | |
| | | lents door and got no | | | | | |
| | response, writer | | | | | | |
| | _ | nt sitting on his bed | | | | | |
| | | ette. Writer asked resident | | | | | |
| | - | cigarette and explained | | | | | |
| | | orohibited in the house. | | | | | |
| | | | | | | | |
| | | cigarette and walked past | | | | | |
| | writer and down | nanway to the | | | | | |
| | courtyard." | | | | | | |
| | The Decident Ser | vices Notes, dated 3/7/11 | | | | | |
| | | • | | | | | |
| | l ` ′ ′ | ted "Resident was see | | | | | |
| | ' ' | ritchen he went in and | | | | | |
| | took some chips | and cheese." | | | | | |
| | The Decident C | Nata - 44: 12/0/11 | | | | | |
| | ine Resident Ser | vices Notes, dated 3/9/11 | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1ZTC12 Facility ID:

004016

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED | | | | | |
|---|--|---|---------|---|---|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | 05/09/2 | |
| | | | B. WINC | | | 05/09/2 | 011 |
| NAME OF | PROVIDER OR SUPPLIE | R | | | DDRESS, CITY, STATE, ZIP CODE | | |
| MONRO | E HOUSE | | | | ADAMS RD IINGTON, IN47403 | | |
| | | CTATEMENT OF DEPLOYMENCIES | | ID | | | (V.5) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION |
| TAG | 1 | R LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | DATE |
| | at 8:00 P.M., inc | | | | | | |
| | resident his snack and residents room was | | | | | | |
| | | lled like cigarette smoke. | | | | | |
| | 1 | I resident that he should | | | | | |
| | 1 | g outside and not in his | | | | | |
| | | told writer that he | | | | | |
| | | would not smoke in his | | | | | |
| | apartment." | | | | | | |
| | | | | | | | |
| | The Resident Services Notes, dated 3/20/11 at 3:00 A.M., indicated "As I was | | | | | | |
| | | | | | | | |
| | | 1 (Not Resident # 9's | | | | | |
| | " | cigarette smoke smell. I | | | | | |
| | 1 '' | dent # 9) had just finished | | | | | |
| | ` | d if he replied "No, I'm in | | | | | |
| | 1 | d him that he cannot | | | | | |
| | smoke in his roo | | | | | | |
| | | | | | | | |
| | The Resident Se | ervices Notes, dated | | | | | |
| | 3/23/11 (no time | e), indicated "Resident | | | | | |
| | was caught smo | king in his room again. | | | | | |
| | _ | red many times not to do | | | | | |
| | this. Hall smells | really bad and other | | | | | |
| | resident are com | nplaining." | | | | | |
| | | | | | | | |
| | The Resident Se | ervices Notes, dated | | | | | |
| | 3/25/11 at 9:55 l | P.M., indicated "Staff | | | | | |
| | (writer) entered | facility through kitchen | | | | | |
| | doors and found | l resident in kitchen. He | | | | | |
| | was going throu | gh cabinets and holding a | | | | | |
| | piece of cake in | his hand. Writer asked | | | | | |
| | resident to leave | kitchen area and | | | | | |
| | explained that for | or resident safety the | | | | | |
| | kitchen was an e | employee only area as | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | (X3) DATE | | |
|---|---|------------------------------|------------------------|---|--------------------------------|---------|------------|
| | | | A. BUILDING B. WING | ì | | 05/09/2 | |
| | | | | REET A | ADDRESS, CITY, STATE, ZIP CODE | ļ | |
| NAME OF I | PROVIDER OR SUPPLIER | R | | | ADAMS RD | | |
| MONRO | E HOUSE | | BL | OOM | IINGTON, IN47403 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | PREF | PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API | | ATE | COMPLETION |
| TAG | + | LSC IDENTIFYING INFORMATION) | TAC | j . | DEFICIENCY) | | DATE |
| | | en entrance door. As | | | | | |
| | writer and resident were exiting kitchen, | | | | | | |
| | | ig in and also spoke with | | | | | |
| | resident about be | | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | |
| | 3/28/11 (no time |), indicated "Resident's | | | | | |
| | daughter (name) | was inwill PU [pick | | | | | |
| | up] resident Fri | 4/1 to visit MD and | | | | | |
| | review lab result | | | | | | |
| | resident's curren | | | | | | |
| | with daughter th | | | | | | |
| | made aware of the recent increase in | | | | | | |
| | behaviors so MI | may do an evaluation to | | | | | |
| | determine appro | priate interventions." | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | |
| | | (3:00 P.M.), indicated | | | | | |
| | | een observed 3 x [times] | | | | | |
| | | around front desk area- | | | | | |
| | 1 . | ome cigarettes, then used | | | | | |
| | | nily to tell them he needs | | | | | |
| | 1 - | nded resident that he had | | | | | |
| | already called so | meone. Resident says | | | | | |
| | someone is bring | ging him some." | | | | | |
| | The Resident Se | rvices Notes, dated | | | | | |
| | | A.M., indicated "Spoke | | | | | |
| | | ame) RE: res [resident] | | | | | |
| | · ` ` | n. Daughter in agreeance | | | | | |
| | 1 | g staff keeping res | | | | | |
| | l ` ′ | s. Spoke with res res in | | | | | |
| | | with keeping smoking | | | | | |
| | | aff et [and] voiced | | | | | |

PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE SURVEY | | |
|--|---|-----------------------------|--------|----------|--|---------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING 00 | | | COMPLETED | | |
| | | | B. WIN | | | 05/09/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| White of Trovider or soft Elek | | | | 1 | ADAMS RD | | |
| MONROE HOUSE | | | | BLOOM | IINGTON, IN47403 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΙΤΕ | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | _ | TAG | DEFICIENCY) | | DATE |
| | ı | being able to ask staff | | | | | |
| | | time he wanted one. res | | | | | |
| | | nd (name) RN to search | | | | | |
| | | oking supplies. Writer | | | | | |
| | only found a pipe | e et 2 lighters res denied | | | | | |
| | having any other | materials." | | | | | |
| | | | | | | | |
| | | vices Notes, dated | | | | | |
| | 4/28/11 (no time) |), indicated "Called sister | | | | | |
| | to come get him to get ciggestes (sic) said sister was coming got off phone walked | | | | | | |
| | | | | | | | |
| | out front door was ask to come back in refused got mad told me to shut up had to go and get help to get in (sic) back in. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | 1 | told us that she wasn't | | | | | |
| | | m. But his (sic) telling | | | | | |
| | everyone she is." | | | | | | |
| | | | | | | | |
| | The Resident Ser | rvices Notes, dated 5/2/11 | | | | | |
| | (no time), indicat | ted "Spoke with res about | | | | | |
| | going out of bldg | g [building]. Explained he | | | | | |
| | | elf and staff would go out | | | | | |
| | 1 | for cigarettes. Res | | | | | |
| | voiced understan | • | | | | | |
| | | <i>o</i> · | | | | | |
| | The Resident Services Notes, dated 5/6/11 2210 (10:10 P.M.), indicated "Resident found to have gone into employee pocket book. Missing money, candy bar and OTC | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | ı | med [medication]. | | | | | |
| | l - | TC med found in | | | | | |
| | 1 - | He had also taken his | | | | | |
| | | | | | | | |
| | | ck of cigarettes found in | | | | | |
| | his room" | | | | | | |

004016

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|-----------------------------|---------|------------------------------|--|---------|--------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER. | | A. BUILDING 00 | | l | 05/09/2011 | | |
| | | | B. WING | | | 03/03/2 | 011 |
| NAME OF | R | | | DRESS, CITY, STATE, ZIP CODE | | | |
| MONROE HOUSE | | | | | IGTON, IN47403 | | |
| | | CTATEMENT OF DEPLOYENCIES | ID ID | | | | (2/5) |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFI | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | | | TAG | | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | DATE |
| | | , | | | | | |
| | The Resident Se | ervices Notes, dated 5/7/11 | | | | | |
| | | dicated "CNA found pills | | | | | |
| | | is nurse had administered | | | | | |
| | | nurse attempted to | | | | | |
| | | meds again and saw res | | | | | |
| | | his tongue. Asked res to | | | | | |
| | 1 * | eports no difficulty | | | | | |
| | | refusal to take med. Said | | | | | |
| | 1 | neds. Will continue to | | | | | |
| | monitor" | icus. Will continue to | | | | | |
| | momtor | | | | | | |
| | In an interview | with the Wellness | | | | | |
| | | /11 at 11:15 A.M., she | | | | | |
| | 1 | edication Resident # 9 had | | | | | |
| | | nex (decongestant | | | | | |
| | | e stated the door to the | | | | | |
| | 1 | room was supposed to be | | | | | |
| | locked. | room was supposed to be | | | | | |
| | locked. | | | | | | |
| | In an interview | with the Wellness | | | | | |
| | | /11 at 11:50 A.M., she | | | | | |
| | 1 | as not aware of any | | | | | |
| | | ments done by the facility. | | | | | |
| | Silloking assessi | nems done by the facility. | | | | | |
| | On 5/9/11 at 11: | 45 A.M., the Residence | | | | | |
| | | ed the facility policy and | | | | | |
| | 1 - | moke Free Policy, dated | | | | | |
| | 1/03. The policy indicated "If any | | | | | | |
| | 1 | | | | | | |
| | current resident that is grandfathered and allowed to continue smoking in his/her apartment because of prior contractual | | | | | | |
| | | | | | | | |
| | 1 - | idangers the health or | | | | | |
| | 1 - | selves or others, they will | | | | | |
| | 1 Wellare of them | berres or outers, they will | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SUR | | | |
|---|---|------------------------------|------------|----------------------|--|------------|-----------|--|
| AND I LAWOF CORRECTION IDENTIFICATION NONIBER. | | A. BUILDING 00 | | COMPLETED 05/09/2011 | | | | |
| | | | B. WIN | | DDDEGG CITY GTATE ZID CODE | 00/03/2011 | 1 | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP CODE ADAMS RD | | | |
| MONROE HOUSE | | | | 1 | IINGTON, IN47403 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re Co | OMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | be immediately prohibited from smoking. | | | | | | | |
| | • | partment and outside of | | | | | | |
| | | r smoking will also be | | | | | | |
| | - | Ethis resident violated | | | | | | |
| | _ | or does not properly | | | | | | |
| | | " In an interview with | | | | | | |
| | | rector, on 5/9/11 at 12:15 | | | | | | |
| | | d Resident # 9 was not | | | | | | |
| | _ | to be smoking in his | | | | | | |
| | apartment. | | | | | | | |
| | | | | | | | | |
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| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COM | TE SURVEY IPLETED 1/2011 | | |
|--|----------------|---|--|---|--------------------------------------|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER MONROE HOUSE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | RRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE | | |
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PRINTED: 05/31/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|---------------------|--|-----------------------|----------------------------|
| | | | A. BUILDING B. WING | | | 05/09/2011 | |
| NAME OF PROVIDER OR SUPPLIER MONROE HOUSE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| R0117 | qualifications, and applicable state la twenty-four (24) he unscheduled need services provided. and training of sta required to provide the residents. A m staff person, with certificates, shall be (50) or more residential administration of rone (1) nursing stall times. Residenthundred (100) res residential nursing of medication, or be (1) additional nursion duty at all times (50) residents. Per only those duties of perform. Employed written job descriptions. Based on recording facility failed to assess residents be practices in that assess a resident and swelling in the services in that assess a resident and swelling in the services in that a system of the services in the | Is of the residents and The number, qualifications, If shall depend on skills It for the specific needs of Inimum of one (1) awake Current CPR and first aid It in one on site at all times. If fifty It is one on site at all times. If fifty It is one on site at all times or Inedication, or both, at least It is for every shall be on site at It is facilities with over one It is one on a different or It is one of the facility receiving It is services or administration It is one of the facilities with over one It is for every additional fifty It is onnel shall be assigned It is one of the facility of the facilities of the facilities of the facilities of pain It is foot and complaints It is one of the facility of the facilities o | R0 | 117 | R 117 410 IAC 16.2-5-1.4 (b) Personnel What corrective action(s) will accomplished for those resider found to have been affected by deficient practice? The Wellness Director re-assess resident #1 on 4/27/2011 post f and found resident to be free freinjury or pain. How the facility will identify or residents having the potential affected by the same deficient | nts y this sed all om | 06/17/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ZTC12 Facility ID:

004016

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 05/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2770 S ADAMS RD MONROE HOUSE **BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 1. Resident #1's clinical record was practice and what corrective action will be taken? reviewed on 5/9/11 at 10:00 A.M. Nurse No other residents were found to be notes indicated the following: affected. "4/10/11 1:57 A.M. Resident called for What measures will be put into place or what systemic changes assistance with complaints of pain in left will the facility make to ensure writer looked at resident foot It was red that the deficient practice does not and Puffy with very little blanching. recur? Writer suggested to resident that he prop The staff at Monroe House was foot on pillow for the night and writer re-educated to our policy and procedure regarding scope of would notify nurses at 7 a.m." This entry practice, change of condition, and the was signed by a Certified Nursing ALC Decision Tree. A licensed assistant. No assessment by a licensed registered nurse is on call 24/7 in nurse concerning the foot was effort to provide assistance with documented in the nurses notes through triage of resident care needs who exhibit a change of condition. 4/17/11. Residents who exhibit a change of condition will be assessed by a "4/25/11 at 3:18 A.M. called on pendant. licensed nurse and/or a licensed went to his room and he was found on his medical professional and knees. He wanted up helped him up. documented within the service notes. Claimed he was in pain. Covered resident How will the corrective action(s) up an checked on his vitals." will be monitored to ensure the deficient practice will not recur, During interview with the Wellness i.e., what quality assurance program will be put into place? Director on 5/5/11 at 10:00 A.M. she For the next three months the indicated she had assessed the resident for Wellness Director or designee will injury on 4/27/11. She further indicated perform a random weekly review of staff had called her but they had told her resident service notes and incident his knees were red and had not said he reports to ensure continued compliance with assessments of hurt. The Wellness Director provided a resident care needs by a licensed Universal Incident/Occurrence Report on medical professional. Findings will 5/5/11 at 10:30 A.M. which indicated the be evaluated at the end of the resident "was found on knees holding on quarter. Findings suggestive of to bed. When staff got him up on his knee compliance will result in no further

FORM CMS-2567(02-99) Previous Versions Obsolete

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| l | OF CORRECTION | IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE Co A. BUILDING B. WING | 00 | COMP 05/09/2 | LETED | | |
|--|---------------------------------------|---|--|--|-----------------|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER MONROE HOUSE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN47403 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | | |
| | he said they hurt Wellness Directo | ." The form indicated the or had been called at 3:36 sted to check on him | | routine monitoring. | | | | |

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